MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03353

Reg. Dist. No. 3510

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 86 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME: Handy Bethard

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Caroline Bethard
6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Sept. 1-1860

8. AGE: Years: 86 | Months: 6 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Berlin, Worcester, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: George Bethard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Joseph N. Shockley
Address: Berlin, Md Rural #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31 47 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Berlin, Md Rural #3

18. Funeral director: Wm O. Timmons
Address: Snow Hill, Md.

19. 3/31/47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1947 to March 28 1947
and that I last saw him alive on March 28 1947

Immediate cause of death	DURATION
Cyanosis	
Pneumonitis.	
Due to	
Due to	
Other conditions: Post-operative shock.	

(Include pregnancy within 3 months of death)

Major findings of operations: Tumor
Date of op. 3-15-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford E. Clark M.D.
M. D. or other
Address: 310 N. Main St. Berlin Md Date signed: 3-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

*03354

Reg. Diat. No. 354

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton — Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred: Died at home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R R # 2 Near Willards
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mamie Adella Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	M

6.(b) Name of husband or wife: Angelo Harrison Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 18th 1890

8. AGE: Years	Months	Days	If less than one day
56	4	11	..... hrs. ..... min.

9. Birthplace: Stockton Md Rural
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: At home

FATHER
12. Name: Irving Henry Holland
13. Birthplace: Worcester Co Md

MOTHER
14. Maiden name: Annie Marshall
15. Birthplace: Worcester Co Md

16. Informant: Angelo Harrison Brown
Address: Stockton Md RR

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Mar 17 1947 (month) (day) (year)
Cemetery or crematory: Mount Hope Cemetery
Location: Near Willards Md

18. Funeral director: Jesse Bennett
Address: Stockton Md

19. Mar 17 1947 (Date rec'd by registrar) Mary M Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12th 1947, at 9.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6th 1947, to March 12 1947
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Apoplexy	1 day
Due to	
Due to Hypertension	2 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. E. Parsons M. D. or other
Address: Pocomoke City Md Date signed: 3/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

03355

Reg. Dist. No. 3-30

1. PLACE OF DEATH:

County: Worcester

City or town: Showell Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Rosalee Campbell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Female	white	widow

6.(b) Name of husband or wife: Frank Campbell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7 - 1871

8. AGE: Years 75 | Months 7 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Kansas City, Kansas

(Town, county and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Harold J. Timmons

Address: Pittsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-47 (month) (day) (year)

Cemetery or crematory: Pitts Creek Baptist Cemetery

Location: Pocomoke City, Md.

18. Funeral director: Henry T. Watson

Address: Pocomoke City, Md.

19. 3/3 (Date rec'd by registrar) 1947 Thos. Coy Berger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1947, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to 19...

and that I last saw her alive on March 1 1947

Immediate cause of death	DURATION
Chronic	
Due to: Myocarditis	
Due to:	
Other conditions: Chr. Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Lowe MD

M. D. or other

Address: Berlin Md. Date signed 3-3-47

3-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

* 03356

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) R D
2.(a) If veteran, name war: No

3.(a) FULL NAME: Bernie Gallick

3.(b) Social Security Number: 216-10-3015

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Lillian R. Gallick
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): June 20 - 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	9	0		

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: Sawer
11. Industry or business: Snake Mill
FATHER 12. Name: Louis Gallick
13. Birthplace: Maryland
MOTHER 14. Maiden name: Isabelle Lynn
15. Birthplace: Maryland
16. Informant: Lillian R. Gallick
Address: Pocomoke City, Rural #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23/47 (month) (day) (year)
Cemetery or crematory: Shiloh Johnson Neck
Location: Pocomoke City, Md Rural
18. Funeral director: Elay E. Dennis
Address: Snow Hill, Md
19. March 22, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 47 at 12 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 December 1946 to March 21 1947 and that I last saw h[illegible] alive on 18 March 1947

Immediate cause of death	DURATION
(a) Paralytic Stroke	
Due to: Hypertensive Cardiovascular Disease (Malignant type	
Due to: Generalized Arteriosclerosis, marked	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dorman E. Santoma, Jr. M.D. or other
Address: Pocomoke City, Md Date signed: 21 Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03357

Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City Rural #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Martha A. Davis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John R. Davis

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): Aug. 8, 1873

8. AGE:

Years	Months	Days	If less than one day
73	7	7	....hrs. ....min.

9. Birthplace: Poulson Accomac Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John Tyler
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Hall
15. Birthplace: Virginia

16. Informant: John W. Davis

Address: 607 Cherry St Pocomoke City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 17 47 (month) (day) (year)

Cemetery or crematory: Downmanville

Location: Oak Hall Md.

18. Funeral director: Elbert E. Timmons

Address: Oak Hall, Md.

19. March 17 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1946 to March 15 1947 and that I last saw her alive on March 15 1947

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease with Cerebral Embolism	1 week.
Due to: Arterio-sclerosis	4 yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ....Injured at work?

23. SIGNATURE: Louis L. Llewelyn, M.D. M.D. or other

Address: Pocomoke City Date signed: 3-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 3510

1. PLACE OF DEATH:

County: Worcester

City or town: Girdletree Rural #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Girdletree Rural #2
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: William E. Douglas

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Dora Douglas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 14 - 1862

8. AGE: Years: 84 | Months: 3 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Girdletree Worcester, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: James Douglas

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mumbows

MOTHER — 15. Birthplace: U

16. Informant: Edward Douglas

Address: Girdletree, Md Rural #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 11 47 (month) (day) (year)

Cemetery or crematory: Stockton Methodist

Location: Stockton Md

18. Funeral director: Elday E. Dennis

Address: Snow Hill Md

19. 3/8 47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 19 47 at 5 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardial degeneration of Heart	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other

Address: Snow Hill Md Date signed: 3/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03359

Reg. Diat. No. 3540

1. PLACE OF DEATH:

County Worcester

City or town Stockton R. D. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Stockton R. D. #1.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harriet Drummond

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	widow

6.(b) Name of husband or wife Frank Drummond

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) March 17, 1879

8. AGE:

Years	Months	Days	If less than one day
68	0	13	hrs. min.

9. Birthplace Temperanceville, Accomac, Va (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Isaac Broughton

13. Birthplace Va

MOTHER

14. Maiden name Unknown

15. Birthplace "

16. Informant Miston Drummond

Address Stockton, Md R.D #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1947 (month) (day) (year)

Cemetery or crematory Jerusalem

Location Oak Hall, Va

18. Funeral director Margarette H. Watson

Address Pocomoke city, Md.

19. Apr. 2 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 30 19 47, at 8 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19 ——, to ——— 19 ——

and that I last saw h alive on 19

Immediate cause of death	DURATION
Myocardial degeneration	Autumn
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L. Riley D.P.S. Md Exam M. D. or other

Address Hunt Hill Md Date signed 5/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03360

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CERTIFICATE OF DEATH

Reg. Dist. No. 3J7

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Mary E. Haskett

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	—

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18 1947

8. AGE: Years | Months | Days | If less than one day: 11 hrs. min.

9. Birthplace: Stockton Worcester Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Willie Haskett
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lenora Evans
15. Birthplace: Virginia

16. Informant: Burnice Evans
Address: Girdletree, Md Rural #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19 1947 (month) (day) (year)
Cemetery or crematory: Stockton Methodist
Location: Stockton, Md

18. Funeral director: Riley & Thomas
Address: Salem Hill, Md

19. Mar 19 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage following childbirth	11 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John L. Riley M.D. or other
Address: Snow Hill Md Date signed: 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 3530

1. PLACE OF DEATH:
County: Worcester
City or town: Selbyville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: Alfred M. Mitchell

3.(b) Social Security Number: 222-05-7774

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1922-5-10

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24	10	11		

9. Birthplace: Del (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER — 12. Name: George Mitchell
FATHER — 13. Birthplace: Del.
MOTHER — 14. Maiden name: Lellie McCray
MOTHER — 15. Birthplace: Del
16. Informant: Helen Handy
Address: Selbyville, Del
17. Buried (Burial, cremation, or removal. Which?) Date thereof: March 23, 1947 (month) (day) (year)
Cemetery or crematory: Antioch, Frankford, Del
Location:
18. Funeral director: Henry N. Watson
Address: Pocomoke, Md.
19. March 23 1947 (Date rec'd by registrar) Mrs Roy Bayly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1947, at 3 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1947 to March 21 1947
and that I last saw him alive on March 21 1947

Immediate cause of death	DURATION
acute myocarditis	3 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Selbyville Date signed: 3-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 8 1947
BUREAU OF

2-35

03362

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred: 107 Pitts St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Pitts St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Abraham Outten

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widower

6.(b) Name of husband or wife: Hester Outten
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 80 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Berlin Wor Co. md (Town, county, and state)
10. Usual occupation: Retired mill worker
11. Industry or business

FATHER
12. Name: Jeremiah Outten.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown.
15. Birthplace: Maryland.

16. Informant: Mrs. Wm Outten
Address: Berlin md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 3/26/47
Cemetery or crematory: Evergreen.
Location: Berlin Md
18. Funeral director: Bruce A. Bunting
Address: Berlin, Md.

19. 3-26 1947 (Date rec'd by registrar) Helen S. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on 9:30 A.M. 3/24/47
Immediate cause of death: Probably Cerebral Hemorrhage — DURATION
Due to:
Due to:
Other conditions: T.B. of Lungs — Several years
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Wm. R. Esposito M.D. M. D. or other
Address: Pocomoke City Md. Date signed: 3/24/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MAR 29 1947
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1 - 53

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03363

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Berlin Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2½ miles S Liberty Camp.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lloyd Ernest Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ethel Elizabeth Powell
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): March 9th 1913

8. AGE: Years	Months	Days	If less than one day
34	0	15	hrs. min.

9. Birthplace: Willards Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: Ernest H. Powell
13. Birthplace: Berlin Md RFD #1

MOTHER
14. Maiden name: Maud L. Carsons.
15. Birthplace: Pittsville Md

16. Informant: Mrs Ethel E. Powell
Address: Berlin Md RFD #1

17. Burial, cremation, or removal. Which? Burial Date thereof 3/27/47 (month) (day) (year)
Cemetery or crematory: Evergreen Mem. Cem.
Location: Days Cross Rd.

18. Funeral director: Dana A. Burbage
Address: Berlin Md.

19. 3-27 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th 1947, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on March 24 1947

Immediate cause of death	DURATION
Probably Coronary Thrombosis	Instant death
Due to:	
Due to: Hypertension	2 yrs +
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. E. Cartonis M.D. Dep. Med. Examiner
M. D. or other
Address: Ocean City Md Date signed 3/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 29 1947
BUREAU OF
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

Reg. Dist. No. 03364 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Worcester.
City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin Md R F D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Powell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife Mary B. Powell
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	15	hrs. min.

9. Birthplace Berlin Wor. Co. Md.
(Town, county, and state)
10. Usual occupation Kennel Manager.
11. Industry or business

FATHER
12. Name Thomas A. Powell.
13. Birthplace Maryland.

MOTHER
14. Maiden name Sarah C. Buttingham
15. Birthplace Maryland.

16. Informant Mrs. Mary B. Powell
Address Berlin Md R F D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/47. (month) (day) (year)
Cemetery or crematory Evergreen.
Location Berlin Md.

18. Funeral director Dana R Burbage.
Address Berlin Md.

19. 3-5 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1947, to March 2 1947.
and that I last saw h. alive on March 2 1947.

Immediate cause of death	DURATION
Arterio sclerotic cardio vascular disease	Unknown
Due to Same	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.
Autopsy results None done.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE H Townsend Jr. M.D.
(M. D. or other)
Address Ocean City, Md. Date signed March 4, 47.

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03365 74

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 3510

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: George W. Pusey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah E. Pusey

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Aug. 23 — 1870

8. AGE:

Years	Months	Days	If less than one day
76	6	11	..... hrs. ..... min.

9. Birthplace: Millsville Sussex Delaware
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Isaac W. Pusey

13. Birthplace: Delaware

MOTHER

14. Maiden name: Mary Jane Truitt

15. Birthplace: Delaware

16. Informant: Mrs. Sarah E. Pusey

Address: Snow Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7/47 (month) (day) (year)

Cemetery or crematory: Mt. Hermon

Location: Snow Hill, Md.

18. Funeral director: Elroy E. Timmons

Address: Snow Hill Md

19. 3/7/ 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1947 at 6 10 P. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept. 18 1946 to March 4 1947 and that I last saw him alive on March 4 1947

	DURATION
Immediate cause of death: Acute Pulmonary Edema and Cardiac Failure	4 days
Due to: Hypertension Cardiovascular Renal Disease	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar M.D.
M. D. or other

Address: Snow Hill Md Date signed 3-6-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

RECEIVED
MAR 10 1947
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03366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester.
City or town Berlin. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin R.F.D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Thomas Quillen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Virginia W. Quillen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1866

8. AGE:	Years	Months	Days	If less than one day
	81	1	26	..... hrs. ..... min.

9. Birthplace Berlin Wor. Co. Md.
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business
FATHER 12. Name Capt. Levi Quillen.
FATHER 13. Birthplace Berlin Md.
MOTHER 14. Maiden name Hettie Mary Richardson
MOTHER 15. Birthplace Berlin Md.
16. Informant Mrs. Edna Quillen.
Address Berlin Md R.F.D
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/47 (month) (day) (year)
Cemetery or crematory Evergreen.
Location Berlin Md.
18. Funeral director Edna A. Burbage
Address Berlin Md.
19. 3-28-1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 March 1947, to 19 Mar 1947
and that I last saw M.M. alive on 19 March 47 1947

Immediate cause of death	DURATION
Massive Cerebral Hemorrhage	5 yrs.
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hernando Robbins M.D.
M. D. or other
Address Berlin, Md. Date signed 21 Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MAR 26 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03367

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred: 818 Second Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Unknown
City or town: Sumpter
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Allen Robinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 8, 1914

8. AGE:

Years	Months	Days	If less than one day
32	10	22	hrs. min.

9. Birthplace: Sumpter South Carolina (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: Allen Robinson
13. Birthplace: Sumpter, S.C.

MOTHER
14. Maiden name: Unknown
15. Birthplace: North Carolina

16. Informant: Mrs. Elizabeth Tull
Address: 818 Second St Pocomoke Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1947 (month) (day) (year)
Cemetery or crematory: Halls Hill Cemetery
Location: Pocomoke City, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City Md.

19. April 2, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1947, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to March 30 1947
and that I last saw h... alive on March 28 1947

Immediate cause of death	DURATION
Due to: Emphysema	
Due to: T.B. Lungs	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W E Jackson M. D. or other
Address: Pocomoke City Md. Date signed: 4/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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Evidence for addition of usual home of deceased shown on:

FILM No. G-109 APR 28 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

03368

Reg. Dist. No. 3-30

1. PLACE OF DEATH:
County: Worcester
City or town: Bishop, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Bishop
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Showell

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: colored
6. (a) ~~Single, married~~, widowed, or ~~divorced~~

6.(b) Name of husband or wife: Charlie Showell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years: 61 62 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Whaleyville, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Anna Whaley
15. Birthplace: Whaleyville, Md.

16. Informant: Thomas Showell
Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22, 1947 (month) (day) (year)
Cemetery or crematory: Sarah Dukes, Bishop, Md.
Location:

18. Funeral director: Henry H. Watson
Address: Pocomoke City, Md.

19. 3/22 1947 Mrs Ray Berger
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1947, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-15- 1947, to 3-20- 1947
and that I last saw h[illegible] alive on 3-20- 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. E. James M. D. or other
Address: Selbyville, Del. Date signed: 3-22-47

VS A15 (9-45-15M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 25 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

03369

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester.
City or town: Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years.
Hospital, Institution, or street address where death occurred: Baltimore Ave Ocean City, Md.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester.
City or town: Ocean City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Dale Showell Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower.

6.(b) Name of husband or wife: Elizabeth Showell.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1864

8. AGE: Years	Months	Days	If less than one day
82	5	3	..... hrs. ..... min.

9. Birthplace: Berlin Wor Co. Md.
(Town, county, and state)
10. Usual occupation: Business man.
11. Industry or business: Bowling alleys Theatre.
FATHER 12. Name: John Dale Showell Sr.
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Mary Burton
15. Birthplace: Delaware
16. Informant: Mrs. John Dale Showell.
Address: Ocean City Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/47 (month) (day) (year)
Cemetery or crematory: St. Pauls.
Location: Berlin Md.
18. Funeral director: Truman A. Burbage
Address: Berlin Md.
19. 3-5- 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1947, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1947, to March 3 1947; and that I last saw h[illegible] alive on March 3 1947.

Immediate cause of death	DURATION
Pulmonary edema.	1. 3 hrs.
Due to: Rt heart failure.	2. 4 days
Due to: Hypertensive cardio-vascular disease	3. Unknown
Other conditions: Unknown-	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Dawson Jr. M.D. M. D. or other
Address: Ocean City Md. Date signed March 4, 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
MAR 8 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:
County: Worcester
City or town: RURAL, Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: RURAL, Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jane Taylor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Frank David Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 24, 1891

8. AGE: Years	Months	Days	If less than one day
55	6	21	hrs. min.

9. Birthplace: Worcester County-Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Private home

FATHER
12. Name: Frank Marshall
13. Birthplace: Accomac County, Virginia

MOTHER
14. Maiden name: Irene Collins
15. Birthplace: Worcester County, Maryland

16. Informant: Frank Taylor
Address: RURAL, Stockton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18, 1947 (month) (day) (year)
Cemetery or crematory: Old Saint Pauls Cemetery
Location: RURAL, Stockton, Maryland

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City, Maryland

19. Apr. 7 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 1945, to March 15 1947
and that I last saw h[illegible] alive on March 15 1947

Immediate cause of death	DURATION
Uraemia	2 yrs
Nephritis	2 yrs
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C E Custer M. D. or other
Address: Pocomoke City, Md. Date signed: 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 10 1947
R—REA